Quality Measures: Population Health Tiger Team
Draft Transcript
October 8, 2010

Presentation

Jesse Singer – DHMH of New York City – Exec. Dir. Development
Thanks, everyone. This is the second of three calls actually. We had our first call last week where we talked about the high priority sub-domain areas. We actually ranked them, so I think we're a little bit ahead of where we were supposed to be. The original plan for this call was to rank the areas. Everyone was supposed to have reviewed the Gretzky Report, the environmental scan from Appendix C, and start thinking about a list of three measures for each of the three sub-domains.

Just to review, I know we had some people that couldn't make it last time, and some of the new folks, so what we had, just briefly, what we had agreed upon was to do this in a data driven methodology where we focus on areas that will have the greatest impact on the number of lives saved. We looked at some vital stats data from the CDC for the top causes of death, and I sent around another paper that talks about deaths due to attributable risk factors and what those risk factors were. Everyone had agreed to look at that as being the goals that we work towards. There's also a lot of consciousness around not building measures for measure's sake, and building measures based upon the goals that we wanted to achieve.

I sent around a couple of things. I sent around those two documents that I just mentioned. I wasn't inundated with comments back from the group, which is definitely understandable. I figure we have three hours. We can do a lot of work on the call. But I think the goal for this call is to really make sure that we're thinking about the measures for each of the three sub-domains. I sent around some proposed measures. We can talk about that.

Just in terms of logistics, I actually have to go around 3:30. I spoke to Aneel, and he— Theresa, I didn't know that you were going to be here. He was your substitute last time.

Terry Cullen – Indian Health Service – Chief Information Officer
That's fine.

Jesse Singer – DHMH of New York City – Exec. Dir. Development
He had agreed to take over for me from 3:30 on. I hope we can get a lot of this out of the way prior to me leaving, but I see the goals of this meeting to work through each of the sub-domains. Start proposing either measure concepts or the measures themselves. I think we get three per domain, per sub-domain, and go from there. Any thoughts? Any objections? Anything?

Steve Solomon – HHS – Deputy Director, Office of Healthcare Quality
That sounds good.

Jesse Singer – DHMH of New York City – Exec. Dir. Development
Lanre was brave enough to compile all of the work that we did and put it into that spreadsheet, the Excel document. I know we don't have a WebEx or a Go-To Meeting set up for this call, so if everyone has taken a look at that or if everyone can take a look at that.

H. Westley Clark – SAMHSA – Director, Center for Substance Abuse Treatment
Yes. This is Dr. Clark from SAMHSA. On the spreadsheet, one of the things that we didn't have an opportunity to do is to suggest alcohol screening given its prevalence both in morbidity and mortality, and that alcohol abuse and addiction are major contributors to heart disease, cancer, stroke, and appear prominently among leading causes of death, as well as morbidity. There are measures to screen for alcohol misuse, so we would strongly encourage that alcohol screening be a part of the measures.

Jesse Singer – DHMH of New York City – Exec. Dir. Development
I think we should definitely put it on the table and just kind of work through. My Excel document is not opening for some reason, but from memory, the first sub-domain that we had ranked first was the healthy lifestyles and behaviors. The second was the effective preventive health measures. The third was health equity. I sent around just some thoughts for brainstorming. I don't know if anyone has had a chance to take a look. I've tried to correlate with what was already out there. I tried to look at what was there for meaningful use in stage one at least for each of the domains.

What some folks had suggested, so just to back up a little bit, so what we decided to do was not to just look at the end states, the outcomes, the causes of death, but really the causes behind the causes, and so those from memory were smoking, tobacco abuse, blood pressure control, obesity, glucose control, physical inactivity. Alcohol was up there. I think it was number seven on that list. So what we were thinking of doing was what could we do that's different? What could we do that's effective in terms of the measures to impact these risks, which are the causes of at least the top four or five causes of death in the country?

I think it was Aneel that suggested originally something like quit rate for smoking instead of, we've got in meaningful use part one, we've got are you a current, former, or never smoker. We have smoking cessation intervention. But one thing that I know folks are very interested in looking at, at ONC, and we've been working on it somewhat here is these delta measures, which are things like quit rate, are things like blood pressure control, how many people improved moving from tier three to tier two to tier one. The same thing with BMI if we're looking at obesity moving from obese to overweight, overweight to normal, those kinds of things.

We can talk about the methodology in a few, but I just wanted to see if we were all on the same page around the measure concepts if we did want to work on tobacco, blood pressure, obesity, and put on the table alcohol screening as well and see. We've got nine measures to propose, so three in each domain. Do folks have thoughts on that?

Terry Cullen – Indian Health Service – Chief Information Officer
I think it's reasonable to do that, to go from beyond measuring something. I guess the only question from a pragmatic perspective and perhaps we don't even want to go there now, is it is something that's in MU one that we can then extend into MU two? For instance, MU one has BMI. Then it might be really reasonable to go overweight to obese and do some stage evaluation. If it's not something that's in MU one at all, then it may be more reasonable in MU two to make it comparable to getting the data in MU two, and then in MU three, moving it to whether you can impact it.

Jesse Singer – DHMH of New York City – Exec. Dir. Development
I agree. Luckily, most of this stuff is in MU one.

Terry Cullen – Indian Health Service – Chief Information Officer
Right.

Jesse Singer – DHMH of New York City – Exec. Dir. Development
But we can definitely leave the table open. Any other thoughts on this? Are folks okay with these measure concept areas: tobacco, blood pressure, obesity?

Terry Cullen – Indian Health Service – Chief Information Officer
Westley, did you think there should be depression in here?

H. Westley Clark – SAMHSA – Director, Center for Substance Abuse Treatment
Now that you mention it, yes. We think perhaps it should be in MU two, diagnostic evaluation. The NQF number is 0103 … belong in there, and it would be an appropriate measure. It's already approved for stages one and two in MU or state two MU, in addition to alcohol screening. Those would be two that would be evolutionary, consistent with what Terry was saying.

Jesse Singer – DHMH of New York City – Exec. Dir. Development
Maybe we should start with the lifestyle behaviors. The strongest evidence that I see in the documents that I sent for things that we can address would be tobacco. I apologize. My Excel document is still just not opening for some reason. Tobacco, blood pressure, obesity: I believe those were the top three, followed by blood glucose. We've got three measures to propose for this sub-domain. We have a limited amount of room. I think obviously alcohol screening, depression screening is important. We have it in all of our practices here in New York. We built it into the EHR. There are definitely some challenges around it, but I think it's worth discussing. In terms of the evidence, in terms of the top causes of the causes of death, it's a little bit further down, but if we had room in our three measure slots to put it, I think we definitely should.

H. Westley Clark – SAMHSA – Director, Center for Substance Abuse Treatment
Where are you getting your causes of death? Alcohol actually from … we can—our data shows that alcohol is in the top five causes of death, so we all agree that, especially if you want to list it under lifestyle behaviors, it's a quantifiable and measurable phenomenon. Oddly enough, even more so than say high blood pressure, which is more physiologic and has a number of contributing things, but the blood pressure and lifestyle is more attenuated than alcohol and lifestyle.

Jesse Singer – DHMH of New York City – Exec. Dir. Development
I guess I would put blood pressure probably in the second sub-domain, which would be effective clinical services. I can't pull it up right now. In terms of healthy lifestyle, I'm looking at smoking and obesity, and then we kind of have this third spot open, which could easily be alcohol screening. I don't think we could afford to do alcohol screening and intervention as two out of the three measures that we use for healthy lifestyle.

H. Westley Clark – SAMHSA – Director, Center for Substance Abuse Treatment
But I think alcohol fits in the healthy lifestyle category as a third measure, more so than hypertension or, rather, physical inactivity because physical inactivity is actually harder to measure. I agree with you that alcohol may be more appropriate as the third measure for healthy lifestyle.

Jesse Singer – DHMH of New York City – Exec. Dir. Development
Great. I definitely want to hear what people think because this is just me shooting off e-mails, but if we could do something in terms of the healthy lifestyle, something with smoking, something with obesity, and something with alcohol. Are folks onboard with that? At least we'll get these concepts down so we know where we're working from.

Steve Solomon – HHS – Deputy Director, Office of Healthcare Quality
Yes. I don't think that anybody would dispute that those are certainly three at the top of the list for problem behaviors that are going to impact health dramatically.

Jesse Singer – DHMH of New York City – Exec. Dir. Development
So we've got those set. Maybe we'll move on to the effective clinical screening, and then we'll come back and start working on the measures for each because the biggest problem I'm having is with the health equity sub-domain. I would love to be able to get to that and get folks' input. But for the second, which was effective clinical preventive screenings, I was looking at blood pressure, and this could be the delta measure moving from one to the next. But I was open to other thoughts on these, on all three of these measures if folks have ideas.

Steve Solomon – HHS – Deputy Director, Office of Healthcare Quality
I would certainly agree with blood pressure and glucose.

H. Westley Clark – SAMHSA – Director, Center for Substance Abuse Treatment
Then we would suggest as a third measure depression, major depressive disorder. It's already been approved by four states, two meaningful use. As I mentioned, it has an NQF 0103.

Jesse Singer – DHMH of New York City – Exec. Dir. Development
Any other thoughts on this?

Terry Cullen – Indian Health Service – Chief Information Officer
I support that we include that.

Jesse Singer – DHMH of New York City – Exec. Dir. Development
We're looking at blood pressure, glucose and depression for the clinical services, and then we can work on some measures as we go. Health equity is something that came up. It was kind of in an effort to bring up to kind of merge environmental factors, social determinants with things that are EHR measurable. Folks are talking about poor access, poor roads causing more accidents if they're in underserved areas, things like that. But those kinds of things are really difficult to measure in an EHR, so we're starting to figure out how could we measure disparities as the population public health tiger team.

Disparities are something that, should we call them out separately? Is there a way to measure them separately? Should they be kind of across tab of the outcomes of the other measures? Of all the measures that we're looking at, should we look at insurance status, payer status? Again, we only get that data on patients who actually do have access and do come in. But this last sub-domain is something I'm pretty at a loss at of what to do. Some folks are thinking should we say percentage of people who had a screening who were on Medicaid, uninsured, by payer status, that kind of thing. I would love to hear any ideas on this third sub-domain.

Steve Solomon – HHS – Deputy Director, Office of Healthcare Quality
All of the six things we've talked about so far, all traditionally show variability based on FCS and/or racial ethnic measures. The question is, did you want to build those in somehow to those six?

Jesse Singer – DHMH of New York City – Exec. Dir. Development
Right.

Terry Cullen – Indian Health Service – Chief Information Officer
This is a subject near and dear to my heart. I think that we should be a little radical here because, remember, these are going to be endorsed in enough time that the software vendors actually could add data fields, or they could start figuring out how to collect this data. I would recommend that we not limit ourselves to what we think is currently collected in EHRs, which are for billing purposes. I realize the SDOs are not in this space, which is a problem, because I don't think Doug Fridsma is going to be able to invoke SNOMED to capture some of this stuff. But it might be helpful for us to look at the things, Jesse, that you just talked about that we know are in "some nontraditional determinants of health" are mostly related to some type of security … or however you want to phrase it and propose that for MU two in this domain, it's actually measuring something. I don't think you're going to be able to move anything.

The problem that I see with Medicaid is healthcare reform is going to be kicking in, in 2013 and 2014. A lot of the access to care stuff is going to happen then. So it may be difficult to get a measure that isn't a moving target just because of healthcare reform. Now maybe that's good, and maybe that's what we should measure is something in terms of access to care there.

Jesse Singer – DHMH of New York City – Exec. Dir. Development
Originally I proposed a sub-domain of access, but just due to the limitations, folks want, as they should, social determinants and environmental factors are as important, so this is kind of a merge of all those. But I think we should be innovative, and I think we should be radical, and I think really the sky is the limit on this. I think we have a really incredible opportunity to set this for the country. If there's data that's important that I agree, we shouldn't try to move the needle on something because there is no baseline to move, I think. I think that I agree totally.

Terry Cullen – Indian Health Service – Chief Information Officer
I will tell you, and Aneel may have shared this. One thing we're looking at is adverse childhood events, adverse childhood experiences and trying to figure out how to collect that data in a standard fashion.

There might be something there, but there's no SDO work in that arena. That's the problem. There's no standard to invoke.

Carol Diamond – Markle– Managing Director Healthcare Program
Guys, I just want to let you know, it's Carol Diamond. I joined the call. Lanre can correct me, but I think when we proposed the three measures, they don't necessarily have to be baked. I think they can be aspirational, and I think this will get passed onto the policy committee, and the SDOs can then kind of deal with what we've given them.

Lanre Akintujoye – ONC
Yes. They can be aspirational.

Jesse Singer – DHMH of New York City – Exec. Dir. Development
Terry, I think we can just do whatever we want basically.

Terry Cullen – Indian Health Service – Chief Information Officer
Okay.

Jesse Singer – DHMH of New York City – Exec. Dir. Development
Any thoughts on this area?

Steve Solomon – HHS – Deputy Director, Office of Healthcare Quality
Is the general idea to look for correlations? Are we trying to correlate or monitor? What's the outcome that we're aiming for? Is it a correlation, as you suggested, to improve either access or the quality of interventions?

Jesse Singer – DHMH of New York City – Exec. Dir. Development
I think it can be a couple of things. Most of the measures, since they've been claimed based traditionally, miss the uninsured, so they're never counted. I think, with EHRs, although there's still the access issue, you have the ability to pool data and to just really shine the light on things that you didn't know that you didn't know.

Terry Cullen – Indian Health Service – Chief Information Officer
I think that's a really good question, and I would agree with Jesse. It's looking at what you might not know, but we also do know that there are huge inequities, and some of it is unclear what the cause is. We know some cause is. We know some causes, but other stuff we don't.

I'll tell you, our interest in something like adverse childhood events is that there's good academic data saying that that those are predictors of chronic disease in adults that in fact far exceed blood pressure. Our goal in looking at that is a long-term look, which is that if we can identify adults or older adolescents or even children that have experienced those that we can case manage them and make them a high; identify them as a vulnerable population and perhaps be able to do some intervention. Now obviously that's long-term. It might not happen.

Steve Solomon – HHS – Deputy Director, Office of Healthcare Quality
I think that makes a lot of sense. As you know, some folks have used fairly sophisticated GIS type approaches to demonstrate relationships just between where someone lives and a whole host of social determinants issues that, depending on how small you can make your geographic unit, you can get a very high degree of correlation with all the things that were discussed, and relate that then to a variety of outcomes, both in terms of risk factors and eventual outcome, especially for chronic disease and injuries.

H. Westley Clark – SAMHSA – Director, Center for Substance Abuse Treatment
GIS data, whether it's zip code based or otherwise, is actually a good observation. Whatever is it we need to do, as Terry pointed out before, it needs to be quantifiable or something that the program can reasonably acquire. The correlations are there. You can do income by zip code approximation or GIS by neighborhood. That includes a wide range of things, including access to fresh fruits and vegetables and

cost of foods, etc. But we just need to come up with something that's quantifiable, I think, even if it's an aspirational objective.

Jesse Singer – DHMH of New York City – Exec. Dir. Development
Yes. Agreed. Zip code is in there. It's in the EHR, but I just don't know how that measurement would happen nationally.

Carol Diamond – Markle– Managing Director Healthcare Program
There is, I'm sure you've heard of this, community health data initiative that HHS is doing where they're putting out large, public data sets, and people have been sort of writing these kinds of apps against them. It's incredible. I looked at the list of the kinds of things that they have data on, and it would boggle your mind, like liquor stores per market area, just incredible things. People have been sort of writing apps and trying to make use of this data, and there are lots and lots of organizations and teams involved. I wonder if this isn't the moment to at least have a conversation internally with HHS to see if there's a way to really connect the direction that they're giving in CHDI to some of the innovators that are building apps that serve these kinds of goals.

Terry Cullen – Indian Health Service – Chief Information Officer
One take off on that because we do have, most EHRs have community and zip code data. In fact, our EHR has lat/lon data by household if somebody offers it, and that's just because of our sanitation database we have. But you could push, and it's not like we do this, but this whole concept of when you sign into an EHR, do you really get a GIS enabled display of your community for some community data set? I don't know whether it's a clustering of diabetes, clustering of accidents, suicide or something. We've thought about that for a long time. We actually haven't done it.

Jesse Singer – DHMH of New York City – Exec. Dir. Development
Yes. We're working on doing some of that with community resources. If you're a diabetic, and you log in, it tells you diabetes education classes, walking groups, healthy bodegas where you can get healthy food.

Terry Cullen – Indian Health Service – Chief Information Officer
But, Jesse, maybe the provider sees that.

Jesse Singer – DHMH of New York City – Exec. Dir. Development
Yes. No, absolutely.

Carol Diamond – Markle– Managing Director Healthcare Program
Amen.

Jesse Singer – DHMH of New York City – Exec. Dir. Development
No, absolutely. We're taking a bit of a patient focused view this year, but there's no reason there shouldn't be both, for sure. My question is just, what would we— We have to come out of here with some measures.

Terry Cullen – Indian Health Service – Chief Information Officer
I see what you're saying. As opposed to just pushing that into certification, it's not a measure.

Jesse Singer – DHMH of New York City – Exec. Dir. Development
Yes. We could say show us your distribution of zip codes and make it public to the community health data project, but we have to come out of here with three measure recommendations or at least some pretty well defined measure concepts.

Terry Cullen – Indian Health Service – Chief Information Officer
One way to do it might be and—Wes, I'd defer to SAMHSA on this is that when you look at adverse childhood events, there are things like severe mental illness in a parent or incarceration of a parent. Those are things that we're not currently collecting in most EHRs, and we know they're predictors of something, definitely predictors of health status impact. Perhaps that's what it is because, if you look at

‘11, it’s like they did screen for tobacco. Well, maybe in ’13 it’s, did you screen for blah because we know blah affects health status.

Jesse Singer – DHMH of New York City – Exec. Dir. Development
Right.

H. Westley Clark – SAMHSA – Director, Center for Substance Abuse Treatment
Yes. I think that’s a very good observation, but I’m trying to conform to Terry’s quantification approach. We know it, as people have been talking, GIS data … a lot of associations now and correlations, if not causations, so a lot of correlations. Now the question for the program that seeing the client is what kind of collateral information can the reasonably get from the patient’s point of view of bringing my child in for a vaccine or sore throat, am I willing to disclose all this other stuff that we would find helpful from the correlation point of view, but the parents might find intrusive from a privacy point of view. That’s the other advantage of the GIS data because you can get things like crime rates and the other things that others have mentioned.

I just wanted to throw in crime rates because that increases the stress in the environment. In those environments, kids tend not to play out as much as other kids, which means that they tend toward obesity because parents are afraid of putting them in the street. Or, and in some cases like in suburbs where there are no sidewalks, so they can’t play. There are a host of variables that we can capture, but the issue remains are people willing to disclose them or can you abstract proxy measures from available databases. One of the things, one study showed was that parents don’t like to talk about criminal behavior. They may not like to talk about psychiatric behavior because they’re fearful of losing their child.

Steve Solomon – HHS – Deputy Director, Office of Healthcare Quality
Jesse, with that in mind, going back to your question about … and raising the question, are we looking for something that could have a delta? Are we looking for something where you can move the needle over time? Is that part of what should be a criterion to consider in identifying a measure?

Jesse Singer – DHMH of New York City – Exec. Dir. Development
I think part of it is, and to Terry’s point is this is such new ground that a lot of times we don’t even have a baseline to move the data. So this may be an opportunity to innovate that way. On the other side is, are we missing an opportunity to—not missing, but we’ve got three measures here. Maybe one of them could be a delta measure. Others can be finding out new data that we previously didn’t know.

A lot of the things that we’re doing in New York revolve around payer status. How many patients are uninsured? How many patients are on Medicaid? How many have commercial or Medicare? We use that to cross-tab all of our measures with, so we get that insurance data with all of our measures. It’s not different than what you would expect in terms of outcomes, but I wonder if that might be something that would be good to put in here just from a national standpoint to make sure that we are looking at—Determinants are also extremely important, and I think there’s definitely room for them. I don’t want us to—if we have the opportunity, if folks think it’s worthwhile to also look at just payer status as an indication of healthcare access.

Steve Solomon – HHS – Deputy Director, Office of Healthcare Quality
To your point about access, it’s not just whether the person shows up and has the capacity to show up for care, but the care that they receive and both the quality, the number of services, and the type of services is correlated both with SES and racial/ethnic variation, as well as with the insurance coverage. Are we looking potentially at an area of whether people are getting differential treatment, I suppose, or different quality of care or different access to certain services even after they’re in the system?

Jesse Singer – DHMH of New York City – Exec. Dir. Development
Yes. I think that’s a great point. If we could find a way to capture that, I think it would be extremely valuable.

H. Westley Clark – SAMHSA – Director, Center for Substance Abuse Treatment

That is a health equity determination, but that's going to be an abstraction based on aggregate data and comparing that person to other data sets depending on the number of interventions and the outcomes. So we want to be careful about that because you're not going to be able to reach a conclusion right away, and it's more of an auditing activity and a research kind of activity based on certain factors. How useful would that be is one of the questions.

Jesse Singer – DHMH of New York City – Exec. Dir. Development
I think this could be converted into kind of measure speak by saying, of everyone with this disease, how many of those with no insurance received X, if we take mammography, for example, which we're seeing a big issue with in terms of disparities with payer status. I think part of the key is choosing what is that outcome that we think is a good indicator of this, but it would be how many women over 50 received mammographies who were on Medicaid, who had no insurance, who had commercial, if we wanted to convert it into a measure?

Part of what we want to do with that here is to look at, well, if people who are uninsured are not getting mammography, we need to increase resources in that area, obviously, and provide free mammographic services and subsidize, and that kind of thing. It will show you pockets where there's, not that we don't know, but where there is the medically underserved and where they're missing specific resources. Part of the trick to that would be figuring out what that über indicator would be, but I think that's how you'd kind of convert it into a measure so that it's useful.

Terry Cullen – Indian Health Service – Chief Information Officer
That's really important though because if we put that in there, theoretically the software is going to have to figure out how to cut and parse the data like that. If it can do it for mammography, it actually should be able to do it for any procedure or anything else you want if people architect it correctly. It may really be a sharp point to just pick one.

It's interesting because we do that for AIA, American Indian, Alaskan Natives, and non-American Indian Alaskan Natives that get care at our clinics because we want to make sure there's not difference there, and if there is, why there is. I think that's measurable, doable, and could get at least software vendors paying attention that this is the ability to slice and dice data based on payer status.

Jesse Singer – DHMH of New York City – Exec. Dir. Development
Would you say one of our recommendations across all of the measures would be to slice and dice it this way?

Terry Cullen – Indian Health Service – Chief Information Officer
That's actually a way to—right—get at the beginnings of health equity.

Jesse Singer – DHMH of New York City – Exec. Dir. Development
Yes.

Steve Solomon – HHS – Deputy Director, Office of Healthcare Quality
I think that's a very good point. Whether it's payer status or zip code or something else, you're still doing kind of a secondary correlation, which could be built in, but as you point out, whether it's with mammography or something else, what you're actually measuring in that visit is the extent to which, particularly if you have a longitudinal record of visits, whether or not a particular patient has gotten the full menu of preventive services, for example, that are in the preventive services taskforce recommendations.

Carol Diamond – Markle– Managing Director Healthcare Program
Can I ask a question? This discussion absolutely makes, and I'm following it, and it makes sense. But I want to go back to one of the things we talked about early one, which was having a defined a set of health priorities or health goals. Over the last week or so, I think Tom Friedman at CDC announced a set of health priorities for the country. I wonder if we shouldn't look at that and get even more specific than preventive services or NPP health priorities or what have you in the sense that he really said, this is what we're going to focus on.

Jesse Singer – DHMH of New York City – Exec. Dir. Development
Do you have those offhand, Carol? I didn't see that.

Carol Diamond – Markle– Managing Director Healthcare Program
Yes. There was an article. I'll try to send it around now.

Aneel Advani – Indian Health Service – Associate Director Informatics
I think one additional conceptual distinction is eligible provider measures, which actually can be measured in a way onto sets of patients versus the sort of single provider, the eligible hospital measures versus the sort of doctor/patient version. I think some of the disparities in measures in access to care that we've discussed may be very appropriate for us to recognize for the eligible hospitals.

Carol Diamond – Markle– Managing Director Healthcare Program
He calls them the six winnable battles in health: smoking, AIDS, obesity/nutrition, teen pregnancy, auto injuries, and healthcare infections.

Jesse Singer – DHMH of New York City – Exec. Dir. Development
We've got smoking and obesity.

Steve Solomon – HHS – Deputy Director, Office of Healthcare Quality
What were the other three, Carol: smoking, health and nutrition, and--?

Carol Diamond – Markle– Managing Director Healthcare Program
Smoking, AIDS, obesity/nutrition, that's one area, teen pregnancy, auto injuries, and healthcare infections.

Lanre Akintujoye – ONC
Healthcare infections is being covered by another tiger team.

H. Westley Clark – SAMHSA – Director, Center for Substance Abuse Treatment
It looks like we've got, other than the healthy hospital-based infections and healthcare infections, we've got most of those. It turns out that alcohol is responsible for 50% of the injuries, auto industries, and associated with teen pregnancy, and would give us greater flexibility in terms of who the providers are because we're not distinguishing between pediatric versus adult in this paradigm, right?

Jesse Singer – DHMH of New York City – Exec. Dir. Development
Right.

H. Westley Clark – SAMHSA – Director, Center for Substance Abuse Treatment
Other than HIV, I think we've covered most of what—the hospital infections and HIV—we basically covered that with the measures we've selected.

Terry Cullen – Indian Health Service – Chief Information Officer
I think the one we don't have, and I would understand why CDC didn't even want to tackle it is the violence, if we're looking at health equity. I think, when we look at causes of death, there's this whole other way to look at it, which is, what are the major causes of loss of life expectancy, which ends up in a different place: violence or comorbidities related. I hate … Wes, keep going here, but I think this whole mental health arena, depression, violence screening, we're not getting at very well.

H. Westley Clark – SAMHSA – Director, Center for Substance Abuse Treatment
I agree with you, and so the question is, how to get to it in such a way that it meets our standards … report.

Terry Cullen – Indian Health Service – Chief Information Officer
What about trauma?

H. Westley Clark – SAMHSA – Director, Center for Substance Abuse Treatment
We could use trauma, like gunshot wounds or—

Terry Cullen – Indian Health Service – Chief Information Officer
Self-reporting.

H. Westley Clark – SAMHSA – Director, Center for Substance Abuse Treatment
Self-reported physical trauma from fights and that sort of thing. That would be a measure, but I don't know about the correlations, and if they've been adequately defined.

Terry Cullen – Indian Health Service – Chief Information Officer
How about domestic violence?

H. Westley Clark – SAMHSA – Director, Center for Substance Abuse Treatment
Domestic violence would be another one of those. Obviously it's in the cluster. It's a high level of psychological, environmental stress, not only for the victim, for any children in the household. Even the perpetrators, oddly enough, are affected by it, so domestic violence would be, but again, how do you define it in such a way that we can quantify it? There are measures of domestic violence …. You guys use it in the Indian Health Service, Terry.

Terry Cullen – Indian Health Service – Chief Information Officer
Yes. We went from a screening rate of 4% to a screening rate of 60%, and while we collect the screening rate. The problem is that we collect the results of the screening, but we don't make them available outside the facility level. Family Violence Prevention Fund would say that's the healthcare response to DV is screening. I know it's U.S. Preventive Taskforce, I think, it's a C or whatever. The problem is it's not an A or a B.

Jesse Singer – DHMH of New York City – Exec. Dir. Development
That was one of the things actually Carol brought up in the initial to just make sure we're not looking at things that don't have any evidence base.

Terry Cullen – Indian Health Service – Chief Information Officer
There's a whole political argument about why that ….

Jesse Singer – DHMH of New York City – Exec. Dir. Development
I'm sure. I don't think it's something we want to get into.

Terry Cullen – Indian Health Service – Chief Information Officer
No.

Carol Diamond – Markle– Managing Director Healthcare Program
Right. I think the question we have to ask ourselves, lots of resources in terms of time and money are going to be directed around these measures. Let's make sure that they are the ones that we think have the highest … if you will in soliciting improvement or encouraging improvement.

Steve Solomon – HHS – Deputy Director, Office of Healthcare Quality
So other than changing, are we talking about whatever these are—whether it's screening or other types of intervention—are we talking about a process whereby, by including it, we're encouraging either patients or providers by having it in the record to try and improve the rate at which services are provided? Is that one goal that we would be aiming for by including a measure under health equity?

H. Westley Clark – SAMHSA – Director, Center for Substance Abuse Treatment
I think that's exactly what we should be trying to achieve because, again, we don't want to impose impossible burdens on the healthcare delivery system because it doesn't really achieve much in the way of quality care or effectiveness or efficiency of care if it's something that they can't affect through either

available resources or access to available resources. I agree with you on that. Otherwise it's epidemiologic data without any immediate or intermediate impact on the healthcare delivery system.

Steve Solomon – HHS – Deputy Director, Office of Healthcare Quality
If we look at the A's or the A's and B's on the preventive services taskforce, are we then saying that for the age appropriate patient that they should be receiving, in the appropriate timeframe, 100%? Is that what we're aiming for? As you just said, Terry, you went from 4% to 60%. Isn't that the type of improvement for particular services that we're looking for?

Terry Cullen – Indian Health Service – Chief Information Officer
Yes. I would say, Jesse's comment about mammography, though I think there's a huge controversy about mammography right now, so I'm avoiding that, but what mammography has pointed out to us is we're unable to budge our number, which is really concerning, and we don't really know what it means. Right, the ability to record it, and I think that that's what this whole thing about blood pressure and obesity, do you go from obesity to overweight to normal weight? How do you move that continuum so that the first step is, can you screen? Then if you can screen, can you modify the results?

Jesse Singer – DHMH of New York City – Exec. Dir. Development
I guess, Terry, one question is, since you've gone from 4% to 60%, what have you seen in terms of have you guys been able to measure improved healthcare outcomes as a result?

Terry Cullen – Indian Health Service – Chief Information Officer
Yes, and we've also been able to measure increased community resources and support services. More people in domestic violence, more people prosecuted and incarcerated. If that's a positive, I don't know that it is, but yes. I guess my only fear is if we focus on what we've always done, I'm not clear how status in America is getting better. Once again, this is my personal thing that there are all these other non-traditional things that we don't pay attention to. I'm not discounting moving a hemoglobin A1c ….

Carol Diamond – Markle– Managing Director Healthcare Program
I agree.

Terry Cullen – Indian Health Service – Chief Information Officer
… important, but ….

Carol Diamond – Markle– Managing Director Healthcare Program
I agree with you.

Terry Cullen – Indian Health Service – Chief Information Officer
You know what? All we're doing is proposing. They can knock it out. Right, Jesse? I mean, we're ….

Jesse Singer – DHMH of New York City – Exec. Dir. Development
Absolutely.

H. Westley Clark – SAMHSA – Director, Center for Substance Abuse Treatment
But we do want to propose something that stands a reasonably good chance of surviving scrutiny, unless we reach the point where it's sort of a … recommendation. I like the domestic violence thing. The screening went from 4% to 60%, and while you have more arrests, the question is, six months later, do you still see the same client, and … she's no longer a victim of domestic violence, so while the screening rate went up to 60%, the incident rate dropped.

Terry Cullen – Indian Health Service – Chief Information Officer
Right. We have that data, but we don't share it publicly, but we monitor that.

H. Westley Clark – SAMHSA – Director, Center for Substance Abuse Treatment

All right. That's a measurable, quantifiable thing. The screening rate went up. The incident rate went down. There's a good measure, and there's a good consequence, and it's more than a correlation. You now have causation because, as a result of the intervention, the person is safer and no longer presents for unnecessary healthcare costs, which would include psychological symptoms of depression of anxiety, physical problems like hypertension, diabetes because that person is much more likely not to adhere to dietary regimen or medication regimen.

Terry Cullen – Indian Health Service – Chief Information Officer
Yes. The problem with domestic violence is this U.S. preventive taskforce C, which I really think it is. I haven't looked in a while, but I think it's still at C.

Jesse Singer – DHMH of New York City – Exec. Dir. Development
I'm all for innovation. I'm all for living on the edge in public health and population health, but we just have to be defensible.

Terry Cullen – Indian Health Service – Chief Information Officer
Right. I'm going to go back to, Jesse, what you said because I don't know if it goes in here, but the ability to stratify data sets based on whatever, insurance, based on the things we know, be it insurance status, income status, which almost every EHR collects. Something like that will help at least—is doable. I think it's defensible, and then is a place to at least get some equity visibility, visibility into equity.

Jesse Singer – DHMH of New York City – Exec. Dir. Development
Would you say we do this across all the measures, or is this something we call out specifically in the health equity sub-domain?

Terry Cullen – Indian Health Service – Chief Information Officer
I don't know.

Jesse Singer – DHMH of New York City – Exec. Dir. Development
I think that's a decision point that maybe we should talk through a little.

Aneel Advani – Indian Health Service – Associate Director Informatics
We went through the last time, and I think the point that Carol made at that point was unless we really sequester the health equity measure sort of more specifically, it won't get the sort of more directed improvement efforts. So, as opposed to making a property of all the measures we recommend, the thought was to actually sequester sort of specifically health equity measures so that they would be ….

Terry Cullen – Indian Health Service – Chief Information Officer
One way to do that, though, Aneel, might be to say stratify. I'm going to pick up … because of who is still dying of cervical cancer in this country. Stratify pap smear rates by income or access to care, insurance status or something is the first one, and the next one is make sure that they're all equal in two years. I think, mammography, because of all the stuff about it, may get—even though we know lower income women have much significant lower mammography rates and get breast cancer diagnoses later, perhaps that is one. I'm a little worried because it's getting so controversial.

Jesse Singer – DHMH of New York City – Exec. Dir. Development
No. I just picked something out of the air. One thing that we're having trouble getting a lot of good data on here is mammography, so that's the only reason. I guess this goes back to my, whether it's pap smear or what, it goes back to do we pick an über measure to stratify that way. I wouldn't mind, to be honest, even though putting the stratification in the health equity section would really focus attention on it. It kind of begs the question why wouldn't we do it for all the other measures as well: blood pressure, tobacco? Preliminarily what we're seeing in our own data is that Medicaid patients get screened and get tested for HIV a lot more than commercial patients.

Terry Cullen – Indian Health Service – Chief Information Officer

Jesse, you know, there is an approach to that, which then says, health equity permeates the delivery of the healthcare system. Our recommendation from a health equity perspective is to require this for every measure.

Aneel Advani – Indian Health Service – Associate Director Informatics
That's good. That's a recommendation.

Jesse Singer – DHMH of New York City – Exec. Dir. Development
That's good.

Steve Solomon – HHS – Deputy Director, Office of Healthcare Quality
It's a shortcut for us, of course.

Jesse Singer – DHMH of New York City – Exec. Dir. Development
It is, but it's kind of an elegant shortcut.

Terry Cullen – Indian Health Service – Chief Information Officer
Nobody is going to be able to ignore it.

Jesse Singer – DHMH of New York City – Exec. Dir. Development
Yes. Would it be …?

Aneel Advani – Indian Health Service – Associate Director Informatics
There will be differences, and the question is really, maybe for our health equity section, we could recommend the actual deltas that would be part of the actual measure because obviously we're not going to get rid of health equities, even if we have complete meaningful use over that next few years. Or we're not going to get rid of health inequity in two years, so just identifying those stratifications is not the same as actually giving the real targets, which of course we can't necessarily do for all the measures just on the parameters of this group, or maybe we could, but we don't know what those other measures are.

Carol Diamond – Markle– Managing Director Healthcare Program
Yes. I'm just a little worried about the implementation of it for everything because I think it's easy to push back on it. That's another strategy for why maybe singling out an area where there's known large disparities may be a more successful strategy, but I don't know.

Jesse Singer – DHMH of New York City – Exec. Dir. Development
I feel, just from our experiences with vendors and this is that if you require for every measure, it's a lot easier to implement than one-offs, but that's just been our experience.

Aneel Advani – Indian Health Service – Associate Director Informatics
Is there something on the health perform side that is sort of a specific outcome that we could synchronize the sort of next version of meaningful use with that rings a bell as far as health equity is concerned?

Terry Cullen – Indian Health Service – Chief Information Officer
Given that so much at ACA is access to care, it's moving people from an uninsured status to an insured status.

Aneel Advani – Indian Health Service – Associate Director Informatics
I think that should be one measure for sure.

Jesse Singer – DHMH of New York City – Exec. Dir. Development
That can be a delta.

Aneel Advani – Indian Health Service – Associate Director Informatics
Access is part of health equity.

Carol Diamond – Markle– Managing Director Healthcare Program
I'm just worried that something like that's going to be available from another data source other than trying to collect it from every EHR.

Jesse Singer – DHMH of New York City – Exec. Dir. Development
I think this puts the onus on the healthcare system and the provider. This is something they're getting measured on, how many folks of theirs did they move. That's one perspective. You're not just seeing these uninsured patients and letting them go. You're getting them into the system and getting them better access.

Carol Diamond – Markle– Managing Director Healthcare Program
Yes. I don't know how that will go over.

Jesse Singer – DHMH of New York City – Exec. Dir. Development
Yes.

Aneel Advani – Indian Health Service – Associate Director Informatics
Maybe we need to think just a little bit more on that thought. I think, as far as meaningful use … to try and get a measure that kind of gets at the sort of administrative parts of the data flow, as well as sort of combining with clinical as a way to … additional content in that measure.

Carol Diamond – Markle– Managing Director Healthcare Program
Right. I think there's a level of indirection here that's not going to be good, and that the population of insured versus uninsured is going to be that data is going to be available elsewhere. I don't think necessarily collecting it for every patient out of every EHR is ….

Aneel Advani – Indian Health Service – Associate Director Informatics
Maybe for the eligible hospitals, we can do it, so insured to uninsured for all groups that we list in the measure, and that gets at that health equity thing because I'm not sure if sort of demographics are necessarily part of the administrative only systems. You might need to actually have clinical information for that. I mean, it still doesn't sort of directly address … Carol.

Carol Diamond – Markle– Managing Director Healthcare Program
Right. I also don't think we should say this in such a way that we have to imply that providers have to not only provide some of these demographic modifiers for people, but also their unique identifiers. I'm a little sort of cautious about how you say this in a way that doesn't sort of imply a big, massive data collection effort. In other words, I don't think all that data should be flowing. I think if the EHR can calculate those things, and we can say it in a way that summaries are reported, then that's better.

Jesse Singer – DHMH of New York City – Exec. Dir. Development
Right. If percentage increase requirements doesn't – we don't have to ask people to give their absolute values, but actually just require a delta for the measure itself, and so then you can't really back substitute in. That sort of addresses what you're saying …. This is sort of a more minor issue than the original issue you raised, Carol, which is, we're sort of trying to keep things clinical.

Aneel Advani – Indian Health Service – Associate Director Informatics
Maybe we should table that one and just keep thinking about actual clinical measures.

Jesse Singer – DHMH of New York City – Exec. Dir. Development
This health equity is hard to achieve and hard to define measures for, so I like the ideas of looking at determinants because this is an idea. We kind of combined access, social determinants, environmental factors. But I just want to make sure that what we do is defensible and has national implications.

Terry Cullen – Indian Health Service – Chief Information Officer
The difficulty is always the pushback we get from our providers. You're asking me to impact something that I can't impact, because the one place to look would be literacy because it affects the clinical setting.

We don't usually collect it in a standard fashion. I know Kaiser has been doing some standard collection on this, and it affects learning style, the ability of the patient to set goals. Maybe there's something in literacy. I don't know if any of the other groups are looking at that.

Jesse Singer – DHMH of New York City – Exec. Dir. Development
I don't know, Lanre, if the patient engagement group is doing anything with health literacy.

Lanre Akintujoye – ONC
I don't think so. I'm not 100% certain on that, but I can check, and I'll get back to the group, but I don't think so.

Terry Cullen – Indian Health Service – Chief Information Officer
Because at least the baseline measure is what percentage of your patients have you assessed for health literacy. This is going to be a lot of work as a measure.

Jesse Singer – DHMH of New York City – Exec. Dir. Development
Yes.

Aneel Advani – Indian Health Service – Associate Director Informatics
… patient communication as part of the EHRs … two parts ….

Steve Solomon – HHS – Deputy Director, Office of Healthcare Quality
How about just in terms of the social determinants, just reporting on whether or not these are being reported, and if we include sort of a menu set, there's probably an argument that we can make that it's the right combination or any particular. In other words, there are some really important correlations that that set of data would capture and some less important ones. But as a set, it's sort of moving us forward.

That just addresses Carol's point of, we're not really letting actual data on the specifics of the patient experience or the actual patient data flow, but it's mostly just more process around that, and that's a start. Then we can sort of later on in the process that it will be easier to add the actual … variables or the actual patient data evaluation in the next group of meaningful use. But for meaningful use 2.0, just have a process measure about how many of these nontraditional terms are actually being reported. That's somewhat aspirational for some EMRs, and maybe not for ours as much.

Jesse Singer – DHMH of New York City – Exec. Dir. Development
You mean like domestic violence, childhood trauma, things like that?

Steve Solomon – HHS – Deputy Director, Office of Healthcare Quality
Yes, well, whatever the set is that we come up with that's sort of politically feasible, as well as sort of really substantial.

Jesse Singer – DHMH of New York City – Exec. Dir. Development
As a single measure.

Steve Solomon – HHS – Deputy Director, Office of Healthcare Quality
Yes. You have three out of five of these at least recorded, 80% of your patients ….

Terry Cullen – Indian Health Service – Chief Information Officer
It seems hard, Aneel.

Aneel Advani – Indian Health Service – Associate Director Informatics
… everybody ….

Terry Cullen – Indian Health Service – Chief Information Officer

I guess my fear is that, well, maybe I shouldn't worry that in the timeframe, can we figure out the five domains and say, here's the standard or crosswalk to it, which I don't know that we can. But at least it does get it on the table … these are important things, so pay attention to them.

Aneel Advani – Indian Health Service – Associate Director Informatics
If we, in large, had passed just the … event type things, but also things that are generally social determinants, so in other words ….

Terry Cullen – Indian Health Service – Chief Information Officer
Education.

Aneel Advani – Indian Health Service – Associate Director Informatics
There could be a floor on some of those, like everybody should really be recording screening rates for something reasonably common, but then there's sort of more aspirational, so people really have a choice of … one change in there to do well on the measure. But as a sum total, it sort of provides a floor to the general EMR market and provides one thing to which people are motivated to have a little bit of featuring, a few features in this area.

Carol Diamond – Markle– Managing Director Healthcare Program
I think that's key. I think you should sort of look at whatever the recommended measures are with the lens of is there something in the impact of this measure that we envision the provider being able to do. I think some of the things that we're talking about may be things that we need to assess at a population level, but maybe the right way to get that information is not through the meaningful use incentives from the EHR. That's my only worry.

Aneel Advani – Indian Health Service – Associate Director Informatics
That's recalling our discussion last time, so we pick some clinically important types of measures or types of data streams that are relevant to social environmental determinants that are still sort of a prime part of this end goal, doctor/patient communications, and not just pick those that are more appropriate for community data sets. So I don't know if we've— Some of these are reasonably clinical. It's not like … part of that interaction if they have enough evidence behind them.

Jesse Singer – DHMH of New York City – Exec. Dir. Development
This sub-domain is pretty brutal for us. I'm not sure.

Aneel Advani – Indian Health Service – Associate Director Informatics
That's why they assigned the smartest people to this group.

Jesse Singer – DHMH of New York City – Exec. Dir. Development
And the most modest.

Terry Cullen – Indian Health Service – Chief Information Officer
I wonder if we're making it harder than it needs to be though. If we look at what most people think is in this thing, it's things like income, safety, education, literacy, cultural sensitivity. Those are all somewhat, as well as lifestyle and gender. Maybe we just need to look at the list of what people would say are contributing to health equity and kind of maybe do what Aneel said. See if there are two or three that rise to the top that we think are provider, are important for providers to collect as opposed to population or public health, and see what's in there. I think I haven't done that myself.

Jesse Singer – DHMH of New York City – Exec. Dir. Development
I haven't.

Terry Cullen – Indian Health Service – Chief Information Officer
We should just get David Kendrick to tell us what to do.

Aneel Advani – Indian Health Service – Associate Director Informatics

We have six people. If we could just think of one that you think is sort of relevant, we may come up with six different answers ….

Terry Cullen – Indian Health Service – Chief Information Officer
We could do that, and we could send it in, in the next two or three days or something.

Carol Diamond – Markle– Managing Director Healthcare Program
Let's try to go through that list now. The first one you said was income.

Terry Cullen – Indian Health Service – Chief Information Officer
I just went on the Canadian Web site, because I think they do this better than us, and I in fact can send everybody what—if I can get to my calendar—what they're saying. Yes, income and social status is the first one. Social support networks, education and literacy, social environment, physical environment, personal health practices, healthy child development, health services, and that's like access to care, gender, and culture.

Aneel Advani – Indian Health Service – Associate Director Informatics
Occupation, employment status, and … sort of ask us to create standards for occupational classifications …. All right. Nobody … inspired.

Jesse Singer – DHMH of New York City – Exec. Dir. Development
Part of it is, I think we all know what the usual is. Race, ethnicity is getting captured in MU one, and insurance status, I think it's important. I think we'd be missing an opportunity to do something with that.

Aneel Advani – Indian Health Service – Associate Director Informatics
Yes. I agree. I think we can make recommendations for eligible hospitals versus eligible providers. There's some things that are actually extremely appropriate for the health facility level that are still sort of in the picture of the provision of direct clinical care that may not be on target for a single doctor. I think insurance status is definitely one of them for the hospital level, especially with health reform. That's a huge goal.

Jesse Singer – DHMH of New York City – Exec. Dir. Development
I think ambulatory definitely plays a role there too with all of our SQHCs and our docs and our medically underserved areas. That really does impact on screening rates, and I really like where we were going, but I think we kind of felt like it was too hard to do around access not just showing up, but accessing being a full provision of appropriate care. Now does that drop off? Kind of what's the endpoint? How do we measure that, the constellation of services?

Aneel Advani – Indian Health Service – Associate Director Informatics
Right.

Terry Cullen – Indian Health Service – Chief Information Officer
I really wonder if literacy is a way to go because it's measurable, and I just know Kaiser has done really good work in this area of how to assess literacy and then how it affects readiness to learn and outcomes.

Aneel Advani – Indian Health Service – Associate Director Informatics
Then Kaiser is using presumably an actual sort of measure.

Terry Cullen – Indian Health Service – Chief Information Officer
They have a measure, and they have a couple different tools, some of which are two or three questions. I don't know this area well enough.

Aneel Advani – Indian Health Service – Associate Director Informatics
We can look ….

Terry Cullen – Indian Health Service – Chief Information Officer

We know health literacy affects everything. It affects compliance. It affects outcome.

Jesse Singer – DHMH of New York City – Exec. Dir. Development
Would this measure look just like an assessment? What percentage of patients did you assess health literacy using the following …?

Terry Cullen – Indian Health Service – Chief Information Officer
Yes. Then what you could go, I mean, long term, Jesse, I'm making this up because I don't really know, but I think you could then go, can you improve that? But also, did that change? Eventually, do you change the way you interact with your patients when you know that. I mean, is there a difference …?

Carol Diamond – Markle– Managing Director Healthcare Program
I think there's going to be tremendous pushback on that, I've got to say.

Terry Cullen – Indian Health Service – Chief Information Officer
Yes, I think so too.

Carol Diamond – Markle– Managing Director Healthcare Program
I just feel like we have so many big issues to tackle. I can't see this floating to the top.

Terry Cullen – Indian Health Service – Chief Information Officer
Yes, except probably the determinant of compliance.

Carol Diamond – Markle– Managing Director Healthcare Program
Yes, or the provider feeling like this is an objective they can take on. I may be wrong about that, but with the all the health priorities on the table.

Terry Cullen – Indian Health Service – Chief Information Officer
No, I agree with your assessment. I think we under-recognize the impact of this though.

Carol Diamond – Markle– Managing Director Healthcare Program
Yes.

Lanre Akintujoye – ONC
Just to interrupt a little bit, I think we're losing Jessie in about 15 minutes, and I think we were having a really good discussion on the health equity piece, and we've kind of broadly identified general categories for the lifestyle behaviors and effective preventive screening. But I was hoping maybe we could go back to those and really just quickly pull out the three measures for each of those categories, and then we can kind of really delve deeply into the health equity and spend the rest of the time on it. Is that okay?

Jesse Singer – DHMH of New York City – Exec. Dir. Development
That sound good. Just so folks know, we only have one more session together next week, so we have to think about, by the end of—I think it's on Wednesday—by the end of that three-hour marathon, we have to be done. I'll just review. For the first, my Excel finally opened. For healthy lifestyle behaviors, I think we agreed the three measure concept areas were tobacco, obesity, and alcohol. For the effective preventive services, we agreed on blood pressure, glucose, and depression. If anyone disagrees, let me know.

I had sent around a couple of ideas on proposed measures, which are all delta type measures, so I think, for tobacco, Aneel had suggested quit rate, which is the delta of current smokers to former smokers. Any thoughts on that, objections?

Carol Diamond – Markle– Managing Director Healthcare Program
I like that.

Frances Cotter – Substance Abuse & MHS Admin. – Program Director
A clarification, are you referring to the measure that you want to propose under MU two because you already have the screening measure in MU one?

Jesse Singer – DHMH of New York City – Exec. Dir. Development
Yes. We have the screening, but this is a quit rate measure.

Frances Cotter – Substance Abuse & MHS Admin. – Program Director
Right. I'm just saying, but if you didn't have the screening measure, you would start with that.

Jesse Singer – DHMH of New York City – Exec. Dir. Development
Probably.

Frances Cotter – Substance Abuse & MHS Admin. – Program Director
Just a clarification. Fine. Go ahead.

Jesse Singer – DHMH of New York City – Exec. Dir. Development
Obesity, I had sent around, now obesity kind of has three broad categories—I'm sorry, BMI. But it's basically obese to overweight, overweight to normal weight. We would construct a delta measure there, and maybe kind of two or three measures in one. It may be obese to overweight, overweight to normal, obese to normal. Any thoughts on that?

Carol Diamond – Markle– Managing Director Healthcare Program
I don't have your e-mail handy, but are you saying the provider would have to report sort of the … or percentage of their population that it into each of those categories?

Jesse Singer – DHMH of New York City – Exec. Dir. Development
I think the measure would be calculated so that it would be however the measure developers want to make it. It could be within the past year or within the past two years, what percentage of your patients move from a BMI over 29 to a BMI less than 25 or something. It would follow that same patient, but we would only end up getting a percentage.

Terry Cullen – Indian Health Service – Chief Information Officer
I think it's a great measure.

Jesse Singer – DHMH of New York City – Exec. Dir. Development
Okay. For the alcohol screening measure, I kind of leave that up to—

Frances Cotter – Substance Abuse & MHS Admin. – Program Director
To SAMSHA?

Jesse Singer – DHMH of New York City – Exec. Dir. Development
Yes.

Frances Cotter – Substance Abuse & MHS Admin. – Program Director
Well, we have been proposing that a version of the IHS and VA measure for alcohol screening and brief intervention be used using the audit. If you do screening, and those who are screened, if they exceed a threshold, they receive brief alcohol counseling. If you wanted to go one step further with a delta measure, you would then say, of those who received brief alcohol counseling, do they change from high problem to lower threshold levels, or you could look at other changes in their behavior. But that's why I asked the question initially because right now there is no MU one measure having to do with simply documenting screening and brief intervention for those who have been screened.

Jesse Singer – DHMH of New York City – Exec. Dir. Development
I think the screening probably fits this instead of quantifying a higher use to a lower use. I imagine, if you guys could send what measure you had proposed for this. It sounds like a bit of a combo of ….

Frances Cotter – Substance Abuse & MHS Admin. – Program Director
That's what it is, and the only reason we're using the VA version rather than the IHS is that the VA applies to both outpatient and the hospital. It's generic. I don't know if the IHS has the one that is listed here is specific to ER, and I didn't know if the IHS has extended it beyond ER.

Terry Cullen – Indian Health Service – Chief Information Officer
Yes. We have a general screening.

Frances Cotter – Substance Abuse & MHS Admin. – Program Director
You do?

Terry Cullen – Indian Health Service – Chief Information Officer
Screen for alcohol, but then we have, in the emergency room, do ASBI because that's where the affects have been proven to be the best.

Frances Cotter – Substance Abuse & MHS Admin. – Program Director
We can talk with you, but we would certainly give one version or another of an ASBI. I think the VA has done the ASBI in both settings, outpatient and emergency room.

Jesse Singer – DHMH of New York City – Exec. Dir. Development
Maybe if you could send that to the group.

Frances Cotter – Substance Abuse & MHS Admin. – Program Director
I will. We had previously sent it to Thomas Sang, but we can certainly send it to you if we get your direct e-mail. I think we have it now, but we are new to this group, so I want to make sure we have everybody's e-mail address. Jesse, at the end, could you give us yours?

Jesse Singer – DHMH of New York City – Exec. Dir. Development
Yes.

Frances Cotter – Substance Abuse & MHS Admin. – Program Director
Or if we send it to you, to ….

Jesse Singer – DHMH of New York City – Exec. Dir. Development
Lanre.

Frances Cotter – Substance Abuse & MHS Admin. – Program Director
Yes. Can you send it out to everyone?

Lanre Akintujoye – ONC
Yes, I can.

Frances Cotter – Substance Abuse & MHS Admin. – Program Director
Thank you. That'll be simpler.

Jesse Singer – DHMH of New York City – Exec. Dir. Development
Great. That's the healthy lifestyle behaviors. Any objections to anything that we mentioned here? Speak now or hold your piece until MU three.

Carol Diamond – Markle– Managing Director Healthcare Program
Can you review, Jesse, just …?

Jesse Singer – DHMH of New York City – Exec. Dir. Development
Sure. Healthy lifestyle behaviors, first domain is smoking or tobacco, I should say, and we were looking. The proposed measure was quit rate. The second one was obesity. The proposed measure was another

delta measure, which was obese to overweight, overweight to normal, and obese to normal. Then the third is the alcohol screening, which SAMSHA will send.

Frances Cotter – Substance Abuse & MHS Admin. – Program Director
And brief intervention, ASBI.

Jesse Singer – DHMH of New York City – Exec. Dir. Development
And brief intervention. That's it for healthy lifestyle. The second sub-domain was effective preventive services, and we agreed on the first measure concept area being blood pressure. The measure that I proposed in the e-mail was patients moving between states. Basically the same as the obesity measure using … C7.

The second one was glucose. This one, I guess we could spend a little time on. I imagine we're all thinking A1c. I'm not familiar, and someone can correct me. I don't believe that there are any tiers in hemoglobin A1c. Some recent literature actually showed that people were having more adverse effects from too much lowering of their A1c, so what do folks think we would do in terms of a delta measure for the blood glucose measure concept area?

Don't everyone talk at once. No thoughts? Maybe what I can do on this is talk with our diabetes folks here at the health department. If anyone has any ideas, definitely send them along.

Steve Solomon – HHS – Deputy Director, Office of Healthcare Quality
The question is, unless it's sort of normally been in an EMR, then adding a categorization or region specific categorization may be … additional burden. So unless it's a standard lab result, it may be better just to actually have a cut off as opposed to multiple categories.

Jesse Singer – DHMH of New York City – Exec. Dir. Development
Or maybe a percentage improvement?

Steve Solomon – HHS – Deputy Director, Office of Healthcare Quality
Yes, that's right, so something that can be calculated from just normally available lab results … additional burden, unless you want to create ….

Terry Cullen – Indian Health Service – Chief Information Officer
Jesse, I think there is a cutoff. I think it's something, but it's not like 6.5. I mean, I think it's three stages: really out of control. Our diabetes program has this. I think it's like less than 9 or 9.5 or something like that as opposed to 7 and below where you're seeing some problems. I think ADA has it stratified.

Jesse Singer – DHMH of New York City – Exec. Dir. Development
I'll take a look.

Terry Cullen – Indian Health Service – Chief Information Officer
I can put you touch with the head of our diabetes program who works closely with them and CDC on this.

Jesse Singer – DHMH of New York City – Exec. Dir. Development
That'd be awesome.

Terry Cullen – Indian Health Service – Chief Information Officer
Yes.

Jesse Singer – DHMH of New York City – Exec. Dir. Development
Basically the same idea for this, we'll get the exact data. Then the third was depression, proposed, I think, Terry and SAMSHA together. You guys back each other up on this one, I think.

Frances Cotter – Substance Abuse & MHS Admin. – Program Director

Yes. On this case, there is an NQF endorsed measure number 103, which is depressive disorder, diagnostic evaluation that would be proposed. Certainly we would love to work with more complex measures, but right now probably need to move forward with assuring that there's diagnostic evaluation.

Jesse Singer – DHMH of New York City – Exec. Dir. Development
This is a screening?

Frances Cotter – Substance Abuse & MHS Admin. – Program Director
Yes. Well, I have to go back. It's an AMA CCTI measure that I'm assuming is screening.

Terry Cullen – Indian Health Service – Chief Information Officer
Yes. It's screening, and it's U.S. preventive taskforce, I think, A or B. The one question will be the ages. I can't remember if U.S. preventive taskforce went down. I think it goes down into adolescents, but I'm not sure.

Jesse Singer – DHMH of New York City – Exec. Dir. Development
Could someone, SAMSHA, I guess?

Frances Cotter – Substance Abuse & MHS Admin. – Program Director
Yes.

Jesse Singer – DHMH of New York City – Exec. Dir. Development
You guys can send this along.

Frances Cotter – Substance Abuse & MHS Admin. – Program Director
We'll do that.

Jesse Singer – DHMH of New York City – Exec. Dir. Development
We can take a happy break and say, I think we're all in alignment on the first two sub-domains. Any objections? Anyone lay it out there if anyone feels like we're misguided or we forgot something. I feel like we did a pretty good job on these first two. I think the delta measures are a nice, innovative outcomes based measurement focused on the goals that are important.

H. Westley Clark – SAMHSA – Director, Center for Substance Abuse Treatment
One possibility for health equity, just to jump ahead a little bit, but related back to, if we think any of these six delta measures should be sort of health equity goals where we just sort of say the delta should be within 80% of each other for all subgroups, and that's where we'll measure of health equity improvement.

Carol Diamond – Markle– Managing Director Healthcare Program
I like that. That makes it less like another set of priorities.

Jesse Singer – DHMH of New York City – Exec. Dir. Development
Would we say, would one measure in the health equity set be for the tobacco, obesity …?

Steve Solomon – HHS – Deputy Director, Office of Healthcare Quality
Yes. We could do one measure for healthy lifestyle behaviors, one measure for prevention, and then if we can create another one for clinical outcomes, that may be in some of the other groups. Then you kind of have a spread.

Jesse Singer – DHMH of New York City – Exec. Dir. Development
I like that. We've got two down. I think we have to get a little specific on the stratifications that we use.

Steve Solomon – HHS – Deputy Director, Office of Healthcare Quality
Right.

Aneel Advani – Indian Health Service – Associate Director Informatics

Maybe for the third health equity, instead of actually enlarging it to any of the group, we could just put in that insurance access thing for hospitals because, for health reform, that'll be really important to actually encourage.

Jesse Singer – DHMH of New York City – Exec. Dir. Development
This is moving from uninsured to insured?

Aneel Advani – Indian Health Service – Associate Director Informatics
Yes. I mean, with the health equity element in there.

Jesse Singer – DHMH of New York City – Exec. Dir. Development
I guess one of the key pieces that we have to do next is come up with a finite number of stratifications that will be applied across all of these.

Carol Diamond – Markle– Managing Director Healthcare Program
Why is that?

Jesse Singer – DHMH of New York City – Exec. Dir. Development
Because I think what we're going to look at is for effective preventive services that between these stratifications, the percentage on these measures should be within 20% of each other.

Carol Diamond – Markle– Managing Director Healthcare Program
I thought what was just proposed was that we do that in the health equity?

Jesse Singer – DHMH of New York City – Exec. Dir. Development
Right.

Aneel Advani – Indian Health Service – Associate Director Informatics
Yes. He's just saying, what do we mean by groups in the health equity.

Carol Diamond – Markle– Managing Director Healthcare Program
I see.

Aneel Advani – Indian Health Service – Associate Director Informatics
That's good. We have a choice of either just one thing or about five possible. So we could just say across racial and ethnic groups or across racial and ethnic groups and income groups or just income groups, or we could …. I don't think we want to hyper-specify right now the exact list, especially if we … if we say racial and ethnic, it'll probably give you the usual suspects … translated into something very specific.

Jesse Singer – DHMH of New York City – Exec. Dir. Development
I have to jump off, luckily, now, but ….

Carol Diamond – Markle– Managing Director Healthcare Program
I actually have to go as well. But I think we've made good progress, Jesse.

Jesse Singer – DHMH of New York City – Exec. Dir. Development
Yes, I think so too. Do folks want to continue?

Terry Cullen – Indian Health Service – Chief Information Officer
We could continue, but I also think we probably all just need to think a little bit about health equity and send something back.

Jesse Singer – DHMH of New York City – Exec. Dir. Development
My feeling is it's probably time to just digest, marinate a little bit on this stuff. We've got our last call on Wednesday, which I think it's another three-hour marathon, but maybe folks can send their— Terry, you

could send me the diabetes info? SAMSHA could send their two measures. We can compile something, and folks can start thinking about—because I think we've got our measures for all of them, including health equity. It's just a matter of what are the groups basically now. So folks can have a chance to think about this over the weekend.

Aneel Advani – Indian Health Service – Associate Director Informatics
… e-mail too ….

Jesse Singer – DHMH of New York City – Exec. Dir. Development
Yes, absolutely. What do people think about that?

Carol Diamond – Markle– Managing Director Healthcare Program
Sounds good.

Terry Cullen – Indian Health Service – Chief Information Officer
Sounds good to me.

Frances Cotter – Substance Abuse & MHS Admin. – Program Director
Sounds good.

Jesse Singer – DHMH of New York City – Exec. Dir. Development
Lanre, are we allowed to do that?

Lanre Akintujoye – ONC
I guess if you guys all feel that way. I guess, on the ONC side, we will be sending a meeting summary of everything we've kind of discussed. I do think you've done a lot in terms of identifying the different measure concepts for the two, the lifestyle behaviors and the active preventive screening. We just have to kind of focus in on equity, and I think that that will be difficult. If we maybe want to do a little bit more brainstorming now, I wouldn't be opposed. But, yes, I think we're okay for the next meeting.

Jesse Singer – DHMH of New York City – Exec. Dir. Development
I think we're ahead of schedule.

Lanre Akintujoye – ONC
Yes.

Terry Cullen – Indian Health Service – Chief Information Officer
Agree. I think everyone wants to jump off, Lanre.

Lanre Akintujoye – ONC
Before we jump off though, we do have to open it up to public comment.

Operator
We have no public comments.

Jesse Singer – DHMH of New York City – Exec. Dir. Development
Thanks. Everyone have a great weekend. I think we really did amazing stuff today, so I'll talk with you guys next week. Please send stuff by e-mail in between, and that's it.

Carol Diamond – Markle– Managing Director Healthcare Program
Great. Thank you.

Jesse Singer – DHMH of New York City – Exec. Dir. Development
Thanks, everyone.

Aneel Advani – Indian Health Service – Associate Director Informatics
Thank you.

Lanre Akintujoye – ONC
Thank you, everyone.